

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002217

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED FEB 6 1963

1. PLACE OF DEATH

a. COUNTY

Jefferson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Four Oaks Home

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

c. CITY
OR
TOWN

St. Louis

Inside Limits
Yes ☐ No ☐d. STREET
ADDRESS

118 Mann Lemay Mo.

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

Elizabeth

First

Middle

Last

Toelle

4. DATE
OF
DEATH

Month

Jan.

Day

24

Year

1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

8-6-81

9. AGE (last birthday)

81

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (City and state or country)

Missouri.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Herain Reighley.

13b. MOTHER'S MAIDEN NAME

Notunk.

Miles.

14. NAME OF HUSBAND OR WIFE

Anton Toelle.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Sylvester Toelle. 118 Mann Lemay.

18. CAUSE OF DEATH (Enter only one cause)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

Left Middle Cerebral Artery thrombosis.
Cerebral Arterial SclerosisINTERVAL BETWEEN
ONSET AND DEATH1 hr.
5 yrs.PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

1/11/63 to 1/24/63

8:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

her
alive on

1/24/63

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Southern Funeral Home.
6322 S. Grand Blvd.

1-28-63

Robert E. Bauer

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

6500

24000

3

4

5

6

7

8

9332X

10

11

1286-0

132-0

FEB 2 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David Van Tassan

Licensed Embalmer No. 4242

P. O. Address Sioux Falls, S.D.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.